STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: The facility reported a census of 21 residents. Based on observation, interview, and record review, the facility failed to implement the written policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property as the facility failed to train 1 of the 4 newly hired staff of the abuse, neglect, and misappropriation policy. The facility also failed to update policies to assure compliance with Section 1150 B of the Social Security Act related to "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility", referenced in the Survey and Certification letter 11-30-NH, dated 6/17/11 and revised on 8/12/2011. Findings included: - During an observation on 5/15/13 at 9:40 a.m., Housekeeping Staff N performed housekeeping duties on the long term care unit. During an interview on 5/15/13 at 9:41 a.m., Staff N reported he/she worked as a housekeeper on the long term care unit for approximately 3	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 226	Continued From page 1 months. Staff N reported he/she received no training related to abuse, neglect, and misappropriation of resident property at the time of hire or in the 3 months since his/her hire date. During an interview on 5/15/13 at 3:45 p.m., Administrative Nursing Staff O reported he/she thought that human resources staff trained and instructed newly hired staff to sign a copy of the abuse, neglect, and misappropriate of resident property policy on the date of hire. During an interview on 5/16/13 at 12:55 p.m., Staff O reported according to Administrative Staff P, new hires received training from department managers on the date of hire about the facility's abuse, neglect, and misappropriation of resident property. During an interview on 5/15/13 at 1:22 p.m., Housekeeping/Maintenance Staff E verified he/she failed to train newly hired employees of the facility's abuse, neglect, and misappropriation of resident property on the date of hire. The facility's 3/3/11 "Abuse, Neglect, and Misappropriation of Property" policy instructed that "new employees will read and sign the Abuse, Neglect, and Misappropriation of Property Policy." The facility failed to ensure newly hired staff received training related to abuse, neglect, and misappropriation of resident property. - Review of the facility's 3/3/11 "Abuse, Neglect, Misappropriation of Property" policy revealed the policy failed to include the Long Term Care Facility's responsibilities included in Section 1105 B of the Social Security Act as related to Federal	F 226		

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F 226	Continued From page 2 requirements for reporting reasonable suspicion of a crime to local law enforcement. During an interview on 5/15/13 at 8:49 a.m., administrative nursing staff A stated the current facility Abuse, Neglect, and Exploitation policy lacked the required information included in the S & C letter 11-30. The current facility policy did not include information regarding reporting reasonable suspicion of a crime in a long term care facility to assure compliance with the requirement. The facility failed to incorporate and implement all requirements of Section 1150 B of the Social Security Act related to "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility", referenced in S&C letter 11-30-NH into their Abuse, Neglect, and Exploitation policy.	F 226		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		

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F 278	Continued From page 3 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility reported a census of 21 residents with 16 sampled for review. Based on observation, interview, and record review, the facility failed to accurately assess 1 of the 16 sampled residents related to pressure ulcers. (#25) Findings included: - Resident #25's 2/14/13 Admission MDS (Minimum Data Set) Assessment reported severely impaired cognition and an entry date to the facility of 2/7/13. The MDS reported the resident presented as high risk to develop pressure ulcers based on the clinical assessment and formal assessment tools with no pressure ulcers present on admission or within the observation period. Resident #25's 2/19/13 Pressure Ulcer CAA (Care Area Assessment) summary reported "on admission the resident was noted to have a blister on [his/her] left heel that measured approximately 9 cm in diameter". The Pressure Ulcer CAA reported the facility planned to include in the resident's care plan interventions to promote healing of the blister.	F 278		

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F 278	Continued From page 4 Resident #25's admission care plan with a revision date of 4/8/13 instructed staff to assist the resident to reposition every 2 hours and as needed to promote comfort, to float his/her heels on pillows while in bed, and that the resident laid on an air mattress. The care plan also directed staff to apply skin repair cream to buttock and coccyx after each toileting, keep linens dry and free of wrinkles, and to perform a skin assessment on first bath day of the week. Resident #25's 2/7/13 admission physician orders included an order for a dressing change daily to bilateral feet. An "Admission Nursing Assessment" dated 2/7/13 revealed resident #25 had scabs to the right forearm, left elbow and identified a "red" area on the left and right buttock. The assessment also identified areas of concern on the right heel and the edge of the right foot. The assessment lacked description or measurements of the areas of concern on the buttocks and the right heel. A section titled "Special Treatment" stated, dressing change to heel daily. Resident #25's 2/7/13 admission nurses' notes stated the resident had a blister to the left heel with a daily dressing change. The admission note lacked identification and measurements of the red areas on the buttocks identified on the Admission Nursing Assessment. Resident #25's 2/15/13 Braden Scale (tool used to predict pressure ulcer risk) score was 18 which indicated moderate risk for pressure ulcer development. During an observation on 5/9/13 at 1:40 p.m.,	F 278		

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F 278	Continued From page 5 licensed nurse S wheeled resident #25 to the hospital for a dressing change to the wound on the resident's coccyx. Licensed nurse T performed a dressing change to the coccyx wound which had a wound vac (device used to promote healing with chronic wounds). Wound measurements on the coccyx wound revealed 1.5 cm (centimeter) deep with a 2 cm of tunneling. The wound measured 3 cm in length and 1.8 cm wide. Another area on the right hip measured 7.7 cm in length and 6.2 cm wide with dark purple circular area in center with an open superficial area measuring 0.7 cm by 1 cm in the center of the wound. During an interview on 5/14/13 at 9:30 a.m. administrative nurse B confirmed resident #25's admission MDS lacked identification of any pressure ulcers present on admission to the facility. He/she stated the CAA for pressure ulcers included a measurement of the blister on the resident's heel. During an interview on 5/15/13 at 7:54 a.m., administrative nurse A stated that an assessment was made of the resident at the hospital prior to admission to the facility by administrative nurse R and him/herself. At the time of admission the resident had a red oval area above the coccyx with a "sheering" appearance. Administrative nurse A stated that about a week later the area had the appearance of a deep tissue injury. He/she also confirmed the resident had a blister on the right heel prior to admission. The facility failed to ensure resident #25's admission MDS assessment accurately reflected the resident's skin condition including the presence of pressure ulcers on the resident's right heel and coccyx.	F 278		

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F 279 SS=D	Continued From page 6 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility had a census of 21 residents, with 16 residents selected for sample. Based on interview and record review, the facility failed to use the results of a comprehensive assessment to develop an individualized care plan for former resident #4, including measurable goals and specific interventions related to the resident's hydration needs. Findings included: - Resident #4's clinical record included physician orders signed on 1/8/13 which noted multiple	F 279 F 279		

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F 279	Continued From page 7	F 279		

diagnoses including "persistent vegetative state" (change in level of consciousness in which a person has partial arousal rather than true awareness of his/her surroundings).

A 12/6/12 Annual MDS (Minimum Data Set) identified resident #4 with long and short term memory problems, moderately impaired decision making abilities, total dependence on staff for all ADLs (activities of daily living) including eating, a weight of 88 lbs (pounds), a loss of liquids from the mouth when drinking, and the presence of dehydration.

The 12/6/12 Annual MDS triggered the area of "Dehydration" for further investigation via the CAAs (care area assessments). According to the Dehydration CAA dated 12/6/12, resident #4, "is at risk for dehydration due to [his/her] overall condition and inability to procure own fluids or communicate if [he/she] wants fluids.... is given fluids with all meals ....takes these with much encouragement... When staff checks and changes [him/her] every 2 hours they offer fluids, [he/she] will generally only take a few sips...."

Resident #4's care plan noted staff review of interventions on 12/27/12. The care plan noted the resident's "potential for dehydration". The "goal" for dehydration included, "Hydration will be maintained as evidenced by normal body temps [temperatures] over the next 90 days." The care plan lacked information as to how body temperatures related to dehydration. The care plan also directed staff to keep fresh water in the room at all times, offer liquids with all interactions, monitor vital signs weekly and as needed, monitor for signs/symptoms of depression and notify the physician and family if dehydration occurred. The care plan lacked individualized

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F 279	Continued From page 8 interventions related to resident #4's specific fluid needs and how staff planned to ensure staff offered the resident that amount of fluids daily. "Hydration Assessments" completed on 9/7/12 and 12/8/12 described resident #4 as "moderate risk" for dehydration. A "Medical Nutritional Therapy" Quarterly progress note dated 9/14/12 calculated resident #4's daily fluid needs as 1420 cc's (cubic centimeters) and average daily intake of 762 cc's of fluid, a deficit of 658 cc's daily. A Nutritional Assessment completed on 12/18/12 calculated resident #4's daily fluid needs as 1023 cc's, with an average daily intake of 526 cc's of fluid, a deficit of 497cc's daily. Nurses Notes included frequent entries in the 4 day time period from 2/16/13 - 2/20/13 related to resident's #4's refusal of fluids. A 2/20/13 entry at 6:15 a.m. noted resident #4's death. During an interview on 5/14/13 at 10:50 a.m., Direct Care Staff M confirmed resident #4 required staff assistance with eating and drinking. Staff M also reported he/she didn't know how much fluids staff were supposed to give the resident, but stated they gave fluids at meals and when they provided care. During an interview on 5/14/13 at 10:00 a.m., Administrative Nurse A confirmed resident #4's care plan lacked a meaningful, measurable goal and individualized interventions related to the resident's specific fluid needs and methods to ensure the resident received adequate fluids daily.	F 279		

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F 279	Continued From page 9 According to the facility's "Hydration/Fluid Maintenance" policy, staff should develop an appropriate preventative plan of care and incorporate a hydration plan based on assessment, responses, outcomes and the needs of the resident. The facility failed to use the results of a comprehensive assessment to develop an individualized care plan for former resident #4, including measurable goals and specific interventions related to the resident's hydration needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility reported a census of 21 residents with	F 280		

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F 280	Continued From page 10 16 residents sampled. Based on observation, interview, and record review the facility failed to review/revise the care plan for 1 sampled resident after the resident experienced multiple falls. Findings included: - Resident # 10's, 4/10/13 Annual MDS (minimum data set) revealed a BIMS (brief interview for mental status) which indicated severely impaired cognitive skills. The assessment also revealed the resident required limited assistance of 1 staff for transfers and walking in room and used a walker and wheelchair for mobility. The assessment further revealed resident #10 had an upper extremity range of motion impairment and had difficulty with balance moving from a seated to standing position, walking, turning around, and was not steady with surface to surface transfer. According to the assessment the resident had no falls since the prior assessment. Resident #10's CAA (care area assessment) dated 4/10/13, triggered for history of falls, with preventative fall measures in place. The 4/11/13 nursing care plan for resident #10 alerted staff that resident #10 had a history of falls resulting in fracture, for staff to evaluate falls, keep bed at lowest position, listen for the personal alarms on the bed and chair and answer promptly. The care plan also directed the staff to use a scoop mattress with a sensor mat. Resident #10's transfer assessment dated 4/4/13 revealed that the resident required only partial assistance with transfer, was unable to bear	F 280		

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F 280	Continued From page 11	F 280		

weight, did not have the upper body strength needed to support weight during transfer. The assessment further revealed the resident was unpredictable and not cooperative or unable to follow commands. The assessment revealed that the resident had conditions of dementia and history of falls. The assessment recommended a full body lift with 2 staff assist.

Review of the Nurses Notes and Fall Documentation sheets revealed the following:

* 3/9/12 at 11:55 p.m.: non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls.
* 3/24/12 non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors of implementation or appropriate fall prevention strategies after the fall to prevent additional falls.
* 4/3/12 at 11:00 p.m.: non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls.
* 2/27/13 at 10:00 p.m.: non- injury fall. The facility added a personal body alarm after the fall.
* 3/6/13 at 10:30 p.m.: non-injury fall. Review or the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls.
* 3/29/13 at 10:28 p.m.: non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls.
* 5/5/13 at 3:40 a.m.: non-injury fall. Review of

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F 280	Continued From page 12 the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls. The facility's fall policy with a revision date of 2/20/2002 directed staff to: * Complete fall risk assessment and note any changes in resident status. * Document in interdisciplinary notes. * Document interventions to minimize falls on the overall care plan * Documentation will support the effectiveness of interventions to prevent falls. Observation on 5/9/13 at 11:00 a.m., revealed direct care staff I and J prompted resident #10 to stand and pivot transfer from wheel chair to recliner in the aviary/ activity room. Resident #10 did not stand upright and required extensive assist. The resident wore non slip socks during transfer. Observation on 5/14/13 at 9:15 a.m., revealed direct care staff L and Administrative staff A transferred resident by gait belt from wheelchair to recliner using a stand pivot transfer. Resident #10 wore a personal body alarm attached to the right shoulder with the alarm box placed on the back of the recliner. During an interview on 5/15/13 at 10:05 a.m., direct care staff K revealed that Resident #10 required the use of a personal body alarm on his/her wheelchair and recliner and a bed alarm while in bed. Staff further stated that resident #10 is transferred with a gait belt and assistance of two staff. Direct care staff K further reported that Resident #10's falls normally happened when	F 280		

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F 280	Continued From page 13 he/she tried to transfer him/herself from one place to another. During an interview on 5/15/13 at 11:20 a.m., licensed staff C revealed that resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 when in the wheelchair or recliner. Licensed staff C reported that resident #10 had less falls since the doctor ordered a long term antibiotic for chronic UTI (urinary tract infection). The facility failed to review/revise resident #10's care plan with appropriate fall prevention strategies after multiple falls.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility reported a census of 21 residents with 16 sampled for review and 1 resident reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure 1 of 1 residents reviewed for pressure ulcers received necessary treatment and services (a system for consistent monitoring and measurements of wounds) in order to promote healing and prevent new sores	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 314	Continued From page 14 from developing. (#25) Findings included: - Resident #25's 3/15/13 physician's orders included multiple medical diagnoses of including weight loss, chronic (persisting for a long period, often for the remainder of a person's lifetime) pain syndrome, CHF (a condition when the heart output is low and the body becomes congested with fluid), dyspnea (distressful sensation of uncomfortable breathing), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). Resident #25's 2/14/13 Admission MDS (Minimum Data Set) Assessment reported the resident had a BIMS (brief interview for mental status) score of 2 which indicated severely impaired cognition and an entry date to the facility of 2/7/13. The resident required extensive assistance of 2 persons for transfers and bed mobility, had no functional limitations in range of motion, and used a wheelchair for mobility. According to the assessment the resident did not have a condition or chronic disease that may result in a life expectance of less than 6 months and did not receive hospice services. The MDS reported the resident presented as high risk to develop pressure ulcers based on the clinical assessment and formal assessment tools with no pressure ulcers present on admission or within the observation period. Skin treatment interventions included pressure relieving devices for the chair/bed and nutrition/hydration interventions to manage skin problems. Resident #25's 3/21/13 Significant Change MDS	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 15 Assessment revealed the resident had a BIMS score of 6 which indicated severe cognitive impairment. The resident required extensive assistance of 2 persons for transfers and bed mobility, had no functional limitations in range of motion, and used a wheelchair for mobility. According to the assessment the resident did not have a condition or chronic disease that may result in a life expectance of less than 6 months and did not receive hospice services. The assessment identified the resident as "at risk" for pressure ulcer development with 1 or more unhealed pressure ulcers at stage 1 or higher, 1 stage 2 pressure ulcer and 1 unstageable pressure ulcer that was present on admission. The assessment documented dimensions of the unstageable pressure ulcer/eschar (dead tissue) as 4 cm (centimeters) by 4.5 cm. Skin treatment interventions included pressure relieving devices for the chair/bed, turning/repositioning program, nutrition/hydration interventions, ulcer care, application of non-surgical dressings and application of dressings to the feet. Resident #25's 2/19/13 Pressure Ulcer CAA (Care Area Assessment) summary from the admission assessment reported "on admission the resident was noted to have a blister on [his/her] left heel that measured approximately 9 cm in diameter". The summary also stated that treatment orders and preventative measures placed. Interventions included keeping the skin clean and dry along with routine monitoring of the skin by the charge nurse, encourage adequate nutrition/hydration, floating heels, pressure relief devices for bed/chair and monitor heel and notify physician of any changes. Resident #25's 3/21/13 Pressure Ulcer CAA summary (from the significant change	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 16 assessment) revealed the resident had an unstageable pressure ulcer on his/her left heel that measured 4 cm by 2.5 cm. The resident also had a stage 2 pressure ulcer on the coccyx that measured 3 cm by 4 cm and currently received wound care treatment at a wound care center. Culture of the coccyx wound revealed Escherichia coli (gram negative bacteria found in lower intestine) treated with Cipro (antibiotic) on 3/18/13. Treatment of the heel included a twice a day Safegel (type of wound dressing) wet to moist dressing change. Orders from the wound care center included repositioning every 2 hours and as needed from side to side, may sit 2 times a day for 20 minutes for meals, and a multiboot splint to the left foot at all times. The summary indicated both the heel and coccyx showed improvement. Resident #25's admission care plan with a revision date of 4/8/13 instructed staff to assist the resident to reposition every 2 hours and as needed to promote comfort, to float his/her heels on pillows while in bed, and used an air mattress for pressure relief. The care plan also directed staff to apply skin repair cream to buttock and coccyx after each toileting, keep linens dry and free of wrinkles, and to perform a skin assessment on first bath day of the week. The nursing care plan included treatment changes on 2/24/13, 2/26/13, 3/11/13, 2/28/13, 4/11/13, 4/25/13 and 5/9/13. The care plan lacked interventions related to the expectations for wound assessments and measurements. Resident #25's 2/7/13 admission physician orders included an order for a dressing change daily to bilateral feet. Further physician's orders included frequent changes to wound treatments on 2/24/13, 3/2/13, 3/3/13, 3/7/13, 3/11/13, 3/13/13,	F 314		

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F 314	Continued From page 17 3/19/13, 3/28/13, 4/11/13, 4/25/13, 5/6/13, and 5/9/13. Resident #25's 2/15/13, 3/17/13, and 5/3/13 Braden Scale (tool used to predict pressure ulcer risk) scores revealed a score of 18 which indicated moderate risk for pressure ulcer development. An "Admission Nursing Assessment" dated 2/7/13 revealed resident #25 had scabs to the right forearm, left elbow and identified a "red" area on the left and right buttock. The assessment also identified areas of concern on the right heel and the edge of the right foot. A section titled "Special Treatment" stated, dressing change to heel daily. The assessment lacked description or measurements of the areas of concern on the buttocks and the right heel. Review of the facility's "Nurses Skin Assessment Tool" completed by licensed nursing staff for resident #25 from 2/19/13 until 5/7/13 revealed completed weekly skin assessment forms. The assessment tool had a body outline to identify areas of concern, a yes/no checklist for red areas, rashes, bruises, open lesions, blisters, open ulcers and dry skin. The form included an area for comments. Review of resident #25's assessments since admission revealed no measurements of pressure ulcers that were present on admission to the facility, a period of 3 months. Resident #25's 2/7/13 admission nurses' notes stated the resident had a blister to the left heel with a daily dressing change. The admission note lacked identification and measurements of the red areas on the buttocks identified on the Admission Nursing Assessment.	F 314		

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F 314	Continued From page 18 Review of resident #25's nurses notes revealed the following: * 2/9/13 at 1:00 p.m. Dressing change to left heel blister, intact, soft dark red, measured approximately 9 cm wide and 4 cm high. * 2/24/13 9:00 a.m. Open area found on right buttock. Cleansed and applied Maxorb/Exuderm. Will continue to monitor. (The resident had red areas on the buttocks on the admission nursing assessment dated 2/7/13. Review of the clinical record lacked documentation of further assessment with the first documentation of an assessment of the area on 2/24/13, a period of 17 days following admission) * 2/26/13 Dressing to right buttock coming off at hs (hour of sleep). Cleansed and redressed....wound bed dark pink with 2 areas side by side 1 cm by 2.5 cm and .5 cm by 1.5 cm. (first documentation of measurements of wound after discovery of wound 2 days earlier on 2/24/13) * 3/6/13 at 9:15 a.m. Left heel wound measured 4 cm by 4.5 cm....Sacral wound described as dark brownish in color and measured 3 cm by 4 cm....foul odor noted, preliminary wound culture back and showed heavy growth of E. Coli (Escherichia coli). Attempted to notify physician. (According to the record, the resident began treatment at a wound care center on 3/11/13) * 3/12/13 at 10:15 a.m. Left heel measurements of 4 cm by 2.5 cm. Area on coccyx measured 5cm x 4 cm. * 3/23/13 at 2:15 p.m. Heel remains 4 cm by 2.5 cm. Coccyx measured 3 cm by 3.5 cm. * 3/26/13 Coccyx measured 3 cm by 3.5 cm with a depth of .75 cm. (no measurements of heel noted) * 3/30/13 Coccyx measured 5 cm by 3 cm with a 1 cm depth (no measurements of heel noted)	F 314		

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	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 314	Continued From page 19 * 4/23/13 at 11:50 p.m. Dressing change to coccyx area measured 4 cm in diameter with 1 cm depth. (No documentation of measurements of the area on the coccyx for a period of 21 days) * 4/29/13 at 10 p.m. Dressing on, wound vac dry and intact. Observed an 8 cm by 6 cm dark purple area on resident's right greater trochanter are, warm and painful to touch. * 5/9/13 at 3:15 p.m. Resident returned from acute care wound vac change, small open area found on right hip measured .7 cm by 1 cm. Wound cleansed and Safegel/vaseline gauze dressings applied. * 5/12/13 at 10:00 a.m. Left heel measured 4 cm x 4.5 cm and .7 cm by 1 cm bruised area on right hip with open slit in center. (According to wound care center notes, the resident had a debridement of the heel wound on 5/6/13. Review of the record lacked documentation of the heel wound measurements from 3/23/13 until 5/12/13, a period of 50 days) Upon request, the facility obtained wound documentation from the acute care side of the facility where the resident received wound vac dressing changes. According to those records, staff assessment of the wound revealed: * 5/9/13 Stage 3 wound to coccyx with deep tissue/necrosis with measurements of 3 cm length, 1.8 cm width, and 1.5 cm depth with tunneling 1.5 - 2 cm. * 5/13/13 Coccyx Stage 4 with loss of skin with extensive destruction, measured 3 cm width and 1.3 cm depth with 2.7 cm tunneling. Stage 2 superficial skin break with redness on left buttock with no measurement recorded. During an observation on 5/9/13 at 1:40 p.m., licensed nurse S wheeled resident #25 to the hospital for a dressing change to the wound on	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 20	F 314		

the resident's coccyx. Licensed hospital nurse T performed a dressing change to the coccyx wound which had a wound vac Wound measurements on the coccyx wound revealed 1.5 cm (centimeter) deep with a 2 cm of tunneling. The wound measured 3 cm in length and 1.8 cm wide. Another area on the right hip measured 7.7 cm in length and 6.2 cm wide with dark purple circular area in center with an open superficial area measuring 0.7 cm by 1 cm in the center of the wound. Licensed nurse T confirmed the area on the right hip was new and also stated the area on the coccyx had improved.

The facility's revised 2/4/11 Wound Protocol procedure directed staff to initiate Weekly Pressure Ulcer Record on admission and update weekly with dressing changes....Fax physician/physician extender, inform of new wounds, pressure ulcers and have them confirm diagnoses.

During an interview on 5/15/13 at 9:48 a.m. direct care staff L stated the CNAs (certified nurse assistants) completed bath sheets during the resident's bath and will notify the nurse if they see anything like skin tears or bruises.

During an interview on 5/9/13 at 3:12 p.m., administrative nurse A stated they discovered the wound on resident #25's right hip on Friday (5/3/13) and the physician saw the resident on Monday (5/6/13). He/she further stated the area was not open when first discovered on 5/3/13.

An interview on 5/10/13 at 9:58 a.m. with administrative nurse A revealed facility staff currently document pressure ulcer measurements and assessments in the nurses ' notes and confirmed there was no system to document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 314	Continued From page 21 on-going assessments of pressure ulcers. Nurse A further stated that resident #25 went to the wound care clinic weekly and he/she would have to call the wound care center for their measurements. During an interview on 5/15/13 at 7:54 a.m., administrative nurse A stated that an assessment was made of the resident at the hospital prior to admission to the facility by administrative nurse R and him/herself. At the time of admission the resident had a red oval area above the coccyx with a "sheering" appearance. Administrative nurse A stated that about a week later the area had the appearance of a deep tissue injury. He/she also confirmed the resident had a blister on the right heel prior to admission. The facility failed to ensure resident #25 received consistent, ongoing nursing assessments and measurements of existing pressure ulcers on the heel and coccyx, in order to promote healing. The facility failed to have a system in place to for consistent monitoring and measurements of wounds.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 21 with 5 residents identified at cognitively impaired and	F 323		

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	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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F 323	Continued From page 22 independently mobile and 3 residents reviewed for accidents. Based on observation, interview and record review the facility failed to ensure the residents ' environment remained free of accidents and hazards for 5 cognitively impaired, independently mobile residents when staff stored potentially hazardous chemicals in an area accessible to residents. The facility also failed to ensure 1 of 3 residents sampled for accidents received adequate supervision to prevent accidents. (Resident #10) Findings included: - Observation on 5/8/13 at 8:30 a.m. revealed the housekeeping closet door marked 220 unlocked and contained the following hazardous chemicals: * Betco cide-bet disinfectant, 5 can, labeled "Keep out of reach of children", causes eye and skin irritation. Do not get in eyes or on skin or clothing. Harmful if swallowed. * Betco ph7q in a spray bottle with no label. According to www.betco.com: Danger: harmful if swallowed, causes eye and skin irritation. * Dispatch disinfectant with bleach, 3 full bottles, labeled avoid contact with eyes, skin and clothing, may cause stomach upset. *Comet cleaner with bleach 2 bottles, labeled "keep out of reach of children, harmful if swallowed. On 5/8/13 at 8:35 a.m., after alerting staff to the opened housekeeping closet door. Housekeeping staff H reported that the staff should lock the door when not in use. During an interview on 5/8/13 at 8:45 a.m.,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 323	Continued From page 23 maintenance staff E confirmed that all housekeeping closet doors should remained locked and inaccessible to the residents. During an interview on 5/15/13 at 4:00 p.m., administrative staff A revealed the facility had 5 residents with cognitive impairment and independently mobile. The facility failed to ensure the resident environment remained as free of accident hazards as possible for 5 cognitively impaired, independently mobile residents when staff failed to lock the housekeeping closet which contained potentially hazardous chemicals. - Resident # 10's, 4/10/13 Annual MDS (minimum data set) revealed a BIMS (brief interview for mental status) score of 4 which indicated severely impaired cognitive skills. The assessment also revealed the resident required limited assistance of 1 staff for transfers and walking in room and used a walker and wheelchair for mobility. The assessment further revealed resident #10 had an upper extremity range of motion impairment and had difficulty with balance moving from a seated to standing position, walking, turning around, and was not steady with surface to surface transfer. According to the assessment the resident had no falls since the prior assessment. Resident #10's CAA (care area assessment) dated 4/10/13, triggered for history of falls with preventative fall measures in place. The 4/11/13 nursing care plan for resident #10 alerted staff that resident #10 had a history of falls resulting in fracture, for staff to evaluate falls, keep bed at lowest position, listen for the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 323	Continued From page 24	F 323		

personal alarms on the bed and chair and answer promptly. The care plan also directed the staff to use a scoop mattress with a sensor mat.

Resident #10 ' s fall assessment dated 1/6/13 and 4/6/13 identified the resident as a " high risk " for falls.

Resident #10's transfer assessment dated 4/4/13 revealed that the resident required only partial assistance with transfer, was unable to bear weight, did not have the upper body strength needed to support weight during transfer. The assessment further revealed the resident was unpredictable and not cooperative or unable to follow commands. The assessment revealed that the resident had conditions of dementia and history of falls.

Review of the Nurses Notes and Fall Documentation sheets revealed the following:
* 3/9/12 at 11:55 p.m.: non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls.
* 3/24/12 non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors of implementation or appropriate fall prevention strategies after the fall to prevent additional falls.
* 4/3/12 at 11:00 p.m.: non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls.
* 2/27/13 at 10:00 p.m.: non- injury fall. The facility added a personal body alarm after the fall.
* 3/6/13 at 10:30 p.m.: non-injury fall. Review or the clinical record revealed no evidence of

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	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 323	Continued From page 25 assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls. * 3/29/13 at 10:28 p.m.: non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls. * 5/5/13 at 3:40 a.m.: non-injury fall. Review of the clinical record revealed no evidence of assessment of the fall for causative factors or implementation of appropriate fall prevention strategies after the fall to prevent additional falls. The facility's fall policy with a revision date of 2/20/2002 directed staff to: * Complete fall risk assessment and note any changes in resident status. * Document in interdisciplinary notes. * Document interventions to minimize falls on the overall care plan * Documentation will support the effectiveness of interventions to prevent falls. Observation on 5/9/13 at 11:00 a.m., revealed direct care staff I and J prompted resident #10 to stand and pivot transfer from wheel chair to recliner in the aviary/ activity room. Resident #10 did not stand upright and required extensive assistance. The resident wore non slip socks during transfer. Observation on 5/14/13 at 9:15 a.m., revealed direct care staff L and Administrative staff A transferred resident by gait belt from wheelchair to recliner using a stand pivot transfer. Resident #10 wore a personal body alarm attached to the right shoulder with the alarm box placed on the back of the recliner.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 323	Continued From page 26 During an interview on 5/15/13 at 10:05 a.m., direct care staff K revealed that Resident #10 required the use of a personal body alarm on his/her wheelchair and recliner and a bed alarm while in bed. Staff further stated that resident #10 is transferred the resident with a gait belt and assistance of two staff. Direct care staff K further reported that Resident #10's falls normally happened when he/she tried to transfer him/herself from one place to another. During an interview on 5/15/13 at 11:20 a.m., licensed staff C revealed that resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 when in the wheelchair or recliner. Licensed staff C reported that resident #10 had less falls since the doctor ordered a long term antibiotic for chronic UTI (urinary tract infection). Licensed staff C stated staff checked the alarms daily to ensure proper functioning. License staff C further stated the facility fall protocol was to access the resident, if the resident is in a lot of pain they are to be taken to the emergency room, the staff also obtains vital signs and looks in to cause of fall. The facility failed to evaluate resident #10's falls for causative factors, implement new fall prevention strategies, monitor for effectiveness of the interventions and modify them as necessary to prevent future falls.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 327	Continued From page 27 This Requirement is not met as evidenced by: The facility had a census of 21 residents, with 16 residents selected for sample. The sample included review of hydration for one resident. Based on interview and record review, the facility failed to have a system in place to ensure 1 of 1 sampled residents received sufficient fluid to maintain proper hydration and health. (Resident #4) Findings included: - Resident #4's clinical record included physician orders signed on 1/8/13 which noted multiple diagnoses including "persistent vegetative state" (change in level of consciousness in which a person has partial arousal rather than true awareness of his/her surroundings). A 12/6/12 Annual MDS (Minimum Data Set) identified resident #4 with long and short term memory problems, moderately impaired decision making abilities, total dependence on staff for all ADLs (activities of daily living) including eating, a weight of 88 lbs (pounds), a loss of liquids from the mouth when drinking, and the presence of dehydration. The 12/6/12 Annual MDS triggered the area of "Dehydration" for further investigation via the CAAs (care area assessments). According to the Dehydration CAA dated 12/6/12, resident #4, "is at risk for dehydration due to [his/her] overall condition and inability to procure own fluids or communicate if [he/she] wants fluids.... is given fluids with all meals ....takes these with much encouragement... When staff checks and changes [him/her] every 2 hours they offer fluids,	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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F 327	Continued From page 28 [he/she] will generally only take a few sips...." Resident #4's care plan noted staff review of interventions on 12/27/12. The care plan noted the resident's "potential for dehydration". The "goal" for dehydration included, "Hydration will be maintained as evidenced by normal body temps [temperatures] over the next 90 days." The care plan lacked information as to how body temperatures related to dehydration. The care plan also directed staff to keep fresh water in the room at all times, offer liquids with all interactions, monitor vital signs weekly and as needed, monitor for signs/symptoms of depression and notify the physician and family if dehydration occurred. The care plan lacked individualized interventions related to resident #4's specific fluid needs and how staff planned to ensure staff offered the resident that amount of fluids daily. "Hydration Assessments" completed on 9/7/12 and 12/8/12 described resident #4 as "moderate risk" for dehydration. A "Medical Nutritional Therapy" Quarterly progress note dated 9/14/12 calculated resident #4's daily fluid needs as 1420 cc's (cubic centimeters) and average daily intake of 762 cc's of fluid, a deficit of 658 cc's daily. A Nutritional Assessment completed on 12/18/12 calculated resident #4's daily fluid needs as 1023 cc's, with an average daily intake of 526 cc's of fluid, a deficit of 497cc's daily. Review of December 2012, January 2013 and February 2013 Fluid Intake records revealed staff recorded identical intake amounts on most of the days during each month, with variations noted in only the quantity of supplements provided.	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 327	Continued From page 29 "Food Intake Records" for January 2013 documented resident #4's food intake for 93 meals the entire month. According to those records, the resident took only 10% of one meal, 15% of one meal, 25% of 12 meals, 50% of 15 meals and 75% of 8 meals. The resident consumed less than 100% of his/her meal 37 of 93 meals during the month of January 2013. During an interview on 5/14/13 at 10:50 a.m., Direct Care Staff M confirmed resident #4 required staff assistance with eating and drinking. According to Staff M, resident #4 took his/her food/fluids better when staff mixed them together and the physician approved of staff doing that. Staff M reported he/she always poured the contents of the glasses/cups containing fluids into the resident's food and then fed from the food containers. Staff M confirmed that process left the fluid glasses empty but, if the resident didn't consume all of the food mixed with the fluid, the resident did not receive the entire quantity of fluids offered even though the fluid containers were empty at the end of the meal. During an interview on 5/14/13 at 11:00 a.m., Dietary Staff F confirmed dietary staff have the responsibility of recording fluid intakes after meals. According to Staff F, he/she goes from table to table and notes the size of the fluid containers and if there are any fluids left at the end of the meal. If he/she sees an empty glass that means the resident consumed all of the fluids and therefore the intake record would reflect that. During an interview on 5/14/13 at 10:00 a.m., Administrative Nurse A confirmed resident #4's care plan lacked a meaningful, measurable goal and individualized interventions related to the	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 327	Continued From page 30 resident's specific fluid needs and methods to ensure the resident received adequate fluids daily. Administrative Nurse A also confirmed staff poured resident #4's fluids into his/her food to alter the consistency of the food because that method improved the resident's intake. Once staff poured the contents of the fluid containers into the containers of food, the fluid containers were empty even if the resident did not consume all of the food/fluid mixture, and dietary staff might assume the resident drank all of the fluids. Upon review of fluid intake records for the month of January 2013, Nurse A confirmed the amounts recorded at each meal were the amounts contained in the glasses/cups offered to the resident and not necessarily the amounts of fluid consumed by resident #4. Nurse A also reported staff do not review the fluid intake sheets on a regular basis to determine if a resident's intake is adequate to meet their needs, even in the case of a resident with a history of dehydration such as resident #4. According to the facility's "Hydration/Fluid Maintenance" policy, staff should develop an appropriate preventative plan of care and incorporate a hydration plan based on assessment, responses, outcomes and the needs of the resident. The facility failed to have a system in place to ensure resident #4 received sufficient fluid to maintain proper hydration and health when staff failed to accurately record the total amount of fluids consumed at each meal rather than the amounts offered at meal time and when staff failed to have a system in place to consistently monitor daily fluid intakes for a resident with a known history of dehydration such as resident #4.	F 327		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 329 SS=E	Continued From page 31 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility reported a census of 21 with 10 residents sampled for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure that 9 of the 10 sampled residents did not receive unnecessary medications when staff failed to monitor for target behaviors related to the use of psychotropic medications for residents # 10, 9, 17, 16, 6, 2, 22, 26, and 7.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 32 Findings included: - Resident # 10's Annual MDS (minimum data set) dated 4/10/13 revealed the resident had severe cognitive impairment and mild depression. The assessment further revealed the resident received 7 days of anti-anxiety and anti-depressant medications during the assessment period. Resident #10's CAA (care area assessment) summary dated 4/10/13 triggered for cognitive loss/ dementia due to diagnosis of dementia, behavioral symptoms due to dementia with some behaviors, mood/ behaviors related to resident becoming agitated and combative. The CAA summary for psychotropic drug use identified the resident developed adverse reactions due to the use of Remeron (an anti-depressant medication) and Xanax (an anti-anxiety medication). The summary further revealed the physician and consultant pharmacist monitored the use of psychotropic medications. Resident #10' s Nursing care plan dated 3/8/13 directed staff to decrease the resident ' s environmental stimuli, provide emotional support, monitor for increasing anxiety and depression and to provide reassurance during times of anxiety. Resident # 10's 5/1/13 physician ' s orders revealed a renewed order for: * Remeron, an anti-depressant, 30 mg (milligrams) every day. * Xanax, an anti-anxiety medication, 0.125 mg every day. Resident # 10's clinical record included a generic	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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F 329	Continued From page 33	F 329		

behavior monitoring form on which staff monitored for a variety of behaviors not specific to resident #10. Review of the behavior monitoring forms lacked evidence staff identified the target behaviors they hoped to control/improve with the use of Remeron and Xanax, and then monitored resident #10 for the presence/ absence of those specific behaviors.

During an observation on 5/14/13 at 4:00 p.m., Resident #10 sat at the dining room table, and did not exhibit any behavioral symptoms or anxiety.

During an interview on 5/15/13 at 8:06 a.m., Administrative Nursing Staff A reported the facility utilized a "mood and behavior" form for all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #10's target behaviors/symptoms while he/she received Remeron and Xanax.

The facility failed to ensure that Resident # 10 did not receive unnecessary medications related to lack of evidence of monitoring target behaviors while resident received Remeron and Xanax.

- Resident #9's 1/5/13 Annual MDS (minimum data set) revealed the resident had severely impaired cognition and no depression. It further revealed resident #9 received 7 days of anti-psychotic, anti-anxiety, and anti- depressant medications during the look back period.

Resident #9's CAA (care area assessment) summary dated 1/5/13 triggered for delirium, cognitive loss/ dementia, psychosocial wellbeing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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F 329	Continued From page 34	F 329		

behavioral symptoms, psychotropic drug use and pain. The summary stated resident #9 had delusions, particularly involving his/her parents and children. The summary further stated the resident becomes angry with staff, becomes restless, anxious and tearful. The summary also stated resident #9 was at high risk for developing drug related side effects due to the use of Invega, Remeron and Xanax.

Resident #9 ' s nursing care plan dated 3/12/13 directed staff to assess and monitor behavior changes, monitor for over sedation of medications and to monitor for side effects of the use of psychotropic drugs. The care plan further directed staff to provide frequent and consistent supervisor for resident #9.

Resident #9's clinical record lacked monitoring for targeted behaviors for the use of Xanax, Invega, Remeron and Buspar. Resident #9's 5/1/13 physician order sheet included renewed orders for:

* Xanax, (an anti-anxiety medication), 0.125 mg (milligram) at noon and in the evening
* Invega, (an anti-psychotic medication), 6mg daily with a diagnosis of unspecified psychosis.
* Remeron (an anti-depressant medication) 30 mg every day
* Buspar, (an anti-depressant medication) 15 mg three times a day

Resident #9's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors not specific to resident #9. Review of the behavior monitoring forms lacked evidence staff identified the target behaviors they hoped to control/improve with the use of Xanax, Invega, Remeron and Buspar and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

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F 329	Continued From page 35	F 329		

then monitored resident #9 for the presence/ absence of those specific behaviors.

During an observation on 5/14/13 at 10:50 a.m., direct care staff L wheeled resident # 9 to his/her room. Staff L offered water to the resident, with no behavioral symptoms or agitation noted.

During an interview on 5/15/13 at 11:15 a.m., Licensed staff C confirmed that resident # 9 wandered in the hallways, could become verbally abusive towards staff, generally anxious and required a wander guard due to pacing in the hallways. Licensed staff C further revealed that all residents have the same behavior sheet which contains one extra box that staff can put in a behavior, with all residents being monitored for the same behaviors.

During an interview on 5/15/13 at 8:06 a.m., Administrative Nursing Staff A reported the facility utilized a "mood and behavior" form for all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #9's target behaviors/symptoms while he/she received Xanax, Remeron, Invega and Buspar.

The facility failed to ensure that Resident # 10 did not receive unnecessary medications when staff failed to adequately monitor for target behaviors while resident #9 received Xanax, Invega, Remeron and Buspar.

- Resident #17's Quarterly MDS (minimum data set) dated 2/22/12 which identified the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 329	Continued From page 36 with intact cognition, no depressin, delirium or hallucination, and anti-pyschotic and anti-depressant use daily. Resident #17's CAA (care area assessment) dated 5/23/13 revealed resident #17's use of pscyhotropic medications. Resident #17's nursing care plan dated 5/4/12 directed staff to monitor for significant physical and psychological change, recview and assess effectiveness of Seroquel (an anti-psychotic medication) and Celexa (an anit-depressant medication.) Resident #17's 5/1/13 physcian's orders revealed renewed orders for: *Seroquel XR 50 mg (milligrams) daily for atypical pschosis with behavioral disturbances. * Celexa 10 mg daily for depressive disorder. Resident #17's clinical record included a generic behaivior monitoring form on which staff monitored for a variety of behaviors no specific to resident #17. Review of the behavior monitoring forms lacked evidence that staff identified the target behaviors they hoped to control/improve with the sue of Seroquel and Celexa, and then monitor resident #17 for the presence/abscense of thsoe specific behaviors. During an observation on 5/8/13 at 8:25 a.m., resdient #17 sat in his/her room sipping on a Pepsi. The resident did not exhibit any behvavioral symptoms. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form forl all	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 329	Continued From page 37	F 329		

residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #17's target behaviors/symptoms while he/she received Seroquel and Celexa.

The facility failed to ensure that resident #17 did not receive uneccessary medications related to the lack of evidence of monitroing target behaviors while residenc received Seroquel and Celexa.

- Resident #16's 3/14/13 Annual MDS (minimum data set) reported intact cognition with no behaviors.

Resident #16's 3/19/13 CAA (care area assessment) summary the resident at risk for developing adverse drug reactions due to daily use of Remeron, Celexa and Rozarem. The summary further revealed that resident #16 shows minimal signs of adverse reactions such as mild shaking in the upper extremeties. The facility will continue to monitor routinely.

Resdient #16's 3/12/12 nursing care plan instruced staff to assess for mood and behavioral changes and document on mood and behavioral flow sheet.

Resident #16's 5/1/13 physcians orders revealed a renewed order for:

* Remeron (an anti-depressant) 7.5 mg (milligram) at bedtime.
* Celexa (an anti-depressant) 20mg daily.

During an observation on 5/8/13 at 12:15 p.m., Resident #16 sat at the dining room table, consumed lunch and conversed with his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 329	Continued From page 38 tablemates. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form forl all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #16's target behaviors/symptoms while he/she received Remeron and Celexa. The facility failed to ensure that resident #16 did not receive uneccessary medications related to the lack of evidence of monitroing target behaviors while residenc received Remeron and Celexa - Resdient #6's Quarterly MDS (minimum data set) dated 3/18/13 identified the resident with moderately impaired cognition, minimal depression, and no behaviors,. Resdient #6's 10/2/12 CAA (care area assessment) summary noted the residents use of psychotropic medications. REsident #6's nursing care plan dated 8/18/12 directed staff to monitor for significant physical and psychological changes, to reveiw and assess the effectivness of the drugs Trazadone and Lexapro. Resident #6's 5/1/13 physcians orders revealed a renewed order for: *Trazadone (an anti-depressant) 150 mg (milligrams) every night at bedtime. * Lexapro (an anti-depressant) 20 mg daily.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 39 During an observation on 5/8/13 at 8:20 a.m., resident #6 sat in a wheelchair in the dining room and consumed morning meal and did not exhibit any behavioral sypmtoms. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form forl all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #6's target behaviors/symptoms while he/she received Trazadone and Lexapro. The facility failed to ensure that resident #6 did not receive uneccessary medications related to the lack of evidence of monitroing target behaviors while residenc received Trazadone and Lexapro. - Resident #2's 5/7/13 signed physician's orders included diagnoses of delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue) with anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). Resident #2's 4/13/13 Quarterly MDS (Minimum Data Set) Assessment reported moderately impaired cognition, mild depression, and delusions. The MDS reported the resident received antipsychotic and antidepressant medications 7 of the 7 observation days.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 40 Resident #2's 1/16/13 Behavior CAA (Care Area Assessment) summary reported the resident experienced delusions related to stating his/her deceased spouse and parents being unable to find him/her. Resident #2's 1/16/13 Mood and Psychotropic Drug Use CAA summaries reported the resident received an antidepressant for depression related to little energy and poor appetite and an antipsychotic medication for delusions. Resident #2's care plan, last reviewed on 4/25/13, instructed staff to monitor for potential side effects and/or adverse consequences for Risperdal (an antipsychotic medication) and Remeron (an antidepressant). Resident #2's 5/7/13 signed physician's orders included renewed orders for Risperdal 0.25 mg (milligrams) orally daily for delusional disorder with anxiety with a start date of 4/4/12 and Remeron 15 mg orally every evening for depression with a start date of 2/8/13. Resident #2's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #2. Review of resident #2's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Risperdal or Remeron, and then lacked monitoring of the presence/absence of those specific behaviors. During an observation on 5/9/13 at 7:58 a.m., resident #2 ate all of his/her meal independently, conversed pleasantly with staff, and made no mention of worries related to his/her family being	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 41	F 329		

unable to find him/her.

During an interview on 5/15/13 at 8:06 a.m., Administrative Nursing Staff A reported the facility utilized the same "mood and behavior" form to document unusual behaviors for all residents regardless of type of medication received. Staff A verified the facility lacked evidence of monitoring resident #2's target behaviors/symptoms while he/she received Risperdal or Remeron.

The facility failed to ensure resident #2 did not receive unnecessary medications related to adequate monitoring as the facility lacked evidence of monitoring target behaviors/symptoms while the resident received Risperdal and Remeron.

- Resident #26's 5/7/13 signed physician's orders included a diagnosis of fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), panic disorder (a sudden overpowering fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

Resident #26's 4/15/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported no cognition impairment, mild depression, and the resident received antipsychotic and antidepressant medication 7 of the 7 observation days. The MDS reported the resident received no antianxiety medication during the observation period.

Resident #26's 4/25/13 Psychosocial Well-being CAA (Care Area Assessment) summary reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 42	F 329		

the resident received Abilify (an antipsychotic medication) for panic attacks, Cymbalta(an antidepressant medication) for depression and fibromyalgia pain, and Clonazepam (an antianxiety medication) for anxiety.

Resident #26's care plan, last reviewed on 4/25/13, instructed staff to monitor for possible side effects and/or adverse consequences while the resident received Abilify, Cymbalta, Clonazepam, and Remeron. The care plan included interventions to allow the resident time and emotional support during times of distress and monitor the effectiveness of pain medications.

Resident #26's 5/7/13 signed physician's orders included renewed orders with start dates of 2/15/13 for Abilify 2 mg (milligrams) orally daily to treat panic disorder and fibromyalgia, Cymbalta 60 mg orally twice a day to treat depression and fibromyalgia, and Clonazepam 0.5 mg orally three times a day to treat anxiety. The 5/8/13 physician's orders included orders for Remeron (an antidepressant medication) 7.5 mg orally at bedtime and to change Clonazepam to 0.5 mg orally in the morning and at noon and 1 mg in the evening.

Resident #'26's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #26. Review of resident #26's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Abilify, Cymbalta, Clonazepam, or Remeron, and then lacked monitoring of the presence/absence of those specific behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 43 During an observation on 5/9/13 at 8:13 a.m., resident #26 ate all of his/her meal independently and showed no outward signs of distress. During an interview on 5/15/13 at 8:06 a.m., Administrative Nursing Staff A reported the facility utilized the same "mood and behavior" form to document unusual behaviors for all residents regardless of type of medication received. Staff A verified the facility lacked evidence of monitoring resident #26's target behaviors/symptoms while he/she received Abilify, Cymbalta, Clonazepam, or Remeron. The facility failed to ensure resident #26 did not receive unnecessary medications related to adequate monitoring as the facility lacked evidence of monitoring target behaviors/symptoms while the resident received Abilify, Cymbalta, Clonazepam, and Remeron. - Resident #22's 5/7/13 signed physician's orders included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). Resident #22's 4/19/13 Quarterly MDS (Minimum Data Set) Assessment reported no cognition impairment, no signs of depression, no psychosis, and no behaviors. The MDS reported the resident received antipsychotic and antidepressant medications 7 of the 7 observation days. Resident #22's 10/17/12 Delirium CAA (Care Area Assessment) summary reported the resident became angry with staff, resisted cares,	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 44	F 329		

and refused medications prior to admission to an acute psychiatric hospital on 9/26/12. The Delirium CAA reported the resident returned on 10/9/12 to the long term care facility with a diagnosis of delirium secondary to a urinary tract infection.

Resident #22's 10/17/12 ADL (Activities of Daily Living) CAA summary reported the resident experienced delusions, screamed out without the ability to articulate why, and accused staff of attempting to hurt him/her. The ADL CAA reported the resident refused to eat or drink at times.

Resident #22's 10/17/12 Behavioral CAA summary reported that staff identified no pattern of what caused the resident to display behaviors and the resident received Zyprexa (an antipsychotic medication), Trazadone (an antidepressant medication), and Lexapro (an antidepressant medication).

Resident #22's care plan, last reviewed on 4/21/13, instructed staff to monitor potential side effects and/or adverse consequences while the resident received Lexapro, Trazadone, and Zyprexa. The care plan instructed staff to monitor for alterations in his/her mood and to document incidents on the "mood and behaviors" form. The care plan instructed staff to monitor for cognitive decline related to dementia.

The 5/7/13 physician's orders included renewed orders for Lexapro 20 mg (milligrams) orally daily with a start date of 12/28/11, Trazadone 25 mg orally at bedtime with an as needed order for an additional 25 mg 1 hour after the scheduled dose with a start date of 12/4/12, and Zyprexa 5 mg orally at bedtime with a start date of 2/8/13.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 45 Resident #'22's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #22. Review of resident #22's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Lexapro, Trazadone, and Zyprexa, and then lacked monitoring of the presence/absence of those specific behaviors. During an observation on 5/8/13 at 8:18 a.m., resident #22 received assistance to eat his/her meal and ate the majority of his/her meal without difficulty or episodes of crying or screaming out. During an interview on 5/15/13 at 8:06 a.m., Administrative Nursing Staff A reported the facility utilized the same "mood and behavior" form to document unusual behaviors for all residents regardless of type of medication received. Staff A verified the facility lacked evidence of monitoring resident #22's target behaviors/symptoms while he/she received Lexapro, Trazadone, and Zyprexa. The facility failed to ensure resident #22 did not receive unnecessary medications related to adequate monitoring as the facility lacked evidence of monitoring target behaviors/symptoms while the resident received Lexapro, Trazadone, and Zyprexa. - Resident #7's 5/7/13 signed physician's orders included a diagnosis of depression (progressive mental disorder characterized by failing memory, confusion). Resident #7's 4/10/13 Quarterly MDS (Minimum	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 46 Data Set) Assessment reported severely impaired cognition, minimal depression, and experienced delusions. The MDS reported the resident displayed physical behaviors toward others and rejected cares 1 to 3 days during the observation period. The MDS reported the resident received antipsychotic and antidepressant medication 7 of the 7 observation days. Resident #7's 8/7/12 Psychotropic Drug Use CAA (Care Area Assessment) summary reported the resident received antidepressant medications and staff monitored for potential side effects and adverse reactions. Resident #7's care plan, last reviewed on 3/18/13, instructed staff to assess for mood changes and provide quality listening time if the resident experienced crying episodes. The care plan instructed staff to monitor for potential side effects and adverse consequences while the resident received antidepressant medications. Resident #7's signed physician's ordered included renewed orders for three antidepressant medications: * Celexa 20 mg (milligrams) orally daily with a start date of 3/4/10 * Wellbutrin XL 75 mg orally daily with a start date of 2/8/13 * Remeron 7.5 mg orally at bedtime with a start date of 5/8/13 Resident #'7's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #7. Review of resident #7's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Celexa,	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 47 Wellbutrin, and Remeron, and then lacked monitoring of the presence/absence of those specific behaviors. During an observation on 5/8/13 at 12:01 p.m., resident #7 received assistance to eat his/her meal and ate the majority of his/her meal without difficulty or episodes of depression. During an interview on 5/15/13 at 8:06 a.m., Administrative Nursing Staff A reported the facility utilized the same "mood and behavior" form to document unusual behaviors for all residents regardless of type of medication received. Staff A verified the facility lacked evidence of monitoring resident #7's target behaviors/symptoms while he/she received Celexa, Wellbutrin, and Remeron. The facility failed to ensure resident #7 did not receive unnecessary medications related to adequate monitoring as the facility lacked evidence of monitoring target behaviors/symptoms while the resident received Celexa, Wellbutrin, and Remeron.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 48 The facility reported a census of 21 residents with one dining room where 20 residents ate meals. Based on observation, interview, and record review, the facility failed to serve food under sanitary conditions when staff touched residents' plates, bowls, and baked potatoes with contaminated gloved hands. This deficient practice affected 20 residents, including residents #26, 2, 22, 13, 9, 18, 23, 16, 25, and 17. Findings included: - During observations of the lunch meal on 5/13/13 at 12:05 p.m., Dietary Staff F put on disposable gloves prior to serving food to the residents and touched 3 of the residents' papers that other staff touched as they wrote each resident's choices, the countertop, and the steam table. Staff F failed to remove the contaminated gloves from his/her hands. Between 12:05 p.m. and 12:38 p.m., Staff F touched with his/her contaminated gloved hands the eating surface of each of the 20 resident's plates and bowls with his/her thumb, touched baked potatoes to cut in half, and placed the potatoes on the residents' plates and served to residents #26, 2, 22, 13, 9, 18, 23, 16, 25, and 17. During an interview on 5/15/13 at 10:10 a.m., Dietary Staff Q reported the facility expected that dietary staff did not touch the residents' food with gloves but used tongs when serving food such as baked potatoes and to touch the residents' plates and bowls on the rims to avoid contaminating the eating surface. The facility's undated "Employee Sanitary Practices" policy instructed staff to "use utensils to handle food" and "pick up dishes by their rims".	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 49 The policy failed to instruct staff to remove contaminated gloves and replace with clean gloves after washing their hands, but instructed staff that "gloves must be worn if raw food is handled". The facility failed to serve food under sanitary conditions when staff touched residents' plates, bowls, and baked potatoes with contaminated gloved hands.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility reported a census of 21 with 10 residents sampled for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure that the consultant pharmacist identified drug irregularities when the pharmacist did not report the lack of monitoring target behaviors to the director of nursing and attending physician for 9 of 10 sampled # 10, 9, 17, 16, 6, 2, 22, 26, and 7. Findings included: - Resident # 10's Annual MDS (minimum data	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 50	F 428		

set) dated 4/10/13 revealed the resident had severe cognitive impairment and mild depression. The assessment further revealed the resident received 7 days of anti-anxiety and anti-depressant medications during the assessment period.

Resident #10's CAA (care area assessment) summary dated 4/10/13 triggered for cognitive loss/ dementia due to diagnosis of dementia, behavioral symptoms due to dementia with some behaviors, mood/ behaviors related to resident becoming agitated and combative. The CAA summary for psychotropic drug use identified the resident developed adverse reactions due to the use of Remeron (an anti-depressant medication) and Xanax (an anti-anxiety medication). The summary further revealed the physician and consultant pharmacist monitored the use of psychotropic medications.

Resident #10' s Nursing care plan dated 3/8/13 directed staff to decrease the resident's environmental stimuli, provide emotional support, monitor for increasing anxiety and depression and to provide reassurance during times of anxiety.

Resident # 10's 5/1/13 physician ' s orders revealed a renewed order for:

* Remeron, an anti-depressant, 30 mg (milligrams) every day.
* Xanax, an anti-anxiety medication, 0.125 mg every day.

Resident # 10's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors not specific to resident #10. Review of the behavior monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 51 forms lacked evidence staff identified the target behaviors they hoped to control/improve with the use of Remeron and Xanax, and then monitored resident #10 for the presence/ absence of those specific behaviors. Resident #10 ' s monthly medication reviews completed on 2/22/12, 3/28/12, 4/24/12, 5/22/12, 6/26/12, 7/31/12, 8/28/12, 9/25/12, 10/31/12, 11/28/12, 12/26/12, 1/22/13, 2/9/13, 3/29/13 and 4/23/13 lacked concerns related to monitoring for target behaviors for the use of Remeron and Xanax. During an observation on 5/14/13 at 4:00 p.m., Resident #10 sat at the dining room table, and did not exhibit any behavioral symptoms or anxiety. During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with the administrative nursing staff R and administrative staff A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #10, while the residents' received medications such as Remeron and Xanax, but could not recall the date. Consultant D verified he/she failed to document the discussion he/she had with administrative nurses A and R. The facility failed to ensure the consultant pharmacist identified drug irregularities related to monitoring of targeted behaviors for Resident #10, who received Remeron and Xanax. - Resident #9's 1/5/13 Annual MDS (minimum data set) revealed the resident had severely impaired cognition and no depression. It further revealed resident #9 received 7 days of	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 52 anti-psychotic, anti-anxiety, and anti- depressant medications during the look back period. Resident #9's CAA (care area assessment) summary dated 1/5/13 triggered for delirium, cognitive loss/ dementia, psychosocial wellbeing, behavioral symptoms, psychotropic drug use and pain. The summary stated resident #9 had delusions, particularly involving his/her parents and children. The summary further stated the resident becomes angry with staff, becomes restless, anxious and tearful. The summary also stated resident #9 was at high risk for developing drug related side effects due to the use of Invega, Remeron and Xanax. Resident #9's nursing care plan dated 3/12/13 directed staff to assess and monitor behavior changes, monitor for over sedation of medications and to monitor for side effects of the use of psychotropic drugs. The care plan further directed staff to provide frequent and consistent supervisor for resident #9. Resident #9's 5/1/13 physician order sheet included renewed orders for: * Xanax, (an anti-anxiety medication), 0.125 mg (milligram) at noon and in the evening * Invega, (an anti-psychotic medication), 6mg daily with a diagnosis of unspecified psychosis. * Remeron (an anti-depressant medication) 30 mg every day * Buspar, (an anti-depressant medication) 15 mg three times a day Resident #9's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors not specific to resident #9. Review of the behavior monitoring	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 53 forms lacked evidence staff identified the target behaviors they hoped to control/improve with the use of Xanax, Invega, Remeron and Buspar and then monitored resident #9 for the presence/ absence of those specific behaviors. Resident #9 ' s monthly medication reviews completed on 2/22/12, 3/28/12, 4/24/12, 5/22/12, 6/26/12, 7/31/12, 8/28/12, 9/25/12, 10/31/12, 11/28/12, 12/26/12, 1/22/13, 2/9/13, 3/29/13 and 4/23/13 lacked concerns for target behaviors for the use of Remeron, Buspar, Xanax and Invega. During an observation on 5/14/13 at 10:50 a.m., direct care staff L wheeled resident # 9 to his/her room. Staff L offered water to the resident, with no behavioral symptoms or agitation noted. During an interview on 5/15/13 at 11:15 a.m., Licensed staff C confirmed that resident # 9 wandered in the hallways, could become verbally abusive towards staff, generally anxious and required a wander guard due to pacing in the hallways. Licensed staff C further revealed that all residents have the same behavior sheet which contains one extra box that staff can put in a behavior, with all residents being monitored for the same behaviors. During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with the administrative staff R and administrative staff A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #9, while the resident received medications such as Remeron and Xanxax, but could not recall the date. Consultant D verified he/she failed to document the discussion he/she had with administrative nurses A and R.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 54 The facility failed to ensure the consultant pharmacist identified drug irregularities related to monitoring of targeted behaviors for resident #9 who received Remeron, Buspar, Xanax and Invega. - Resident #17's Quarterly MDS (minimum data set) assessment dated 2/22/12 revealed the resident had intact cognition, no depression, delirium or hallucinations, and received anti-psychotic and anti-depressant therapy daily. Resident #17's CAA (care area assessment) dated 5/23/12 confirmed resident #17's use of psychotropic medications. Resident #17's nursing care plan dated 5/4/12 directed staff to monitor for significant physical and psychological change, review and assess effectiveness of Seroquel (an anti-psychotic medication) and Celexa (an anti-depressant medication.) Resident #17's 5/1/13 physician ' s orders revealed renewed orders for: * Seroquel XR 50 mg (milligrams) daily for atypical psychosis with behavioral disturbances * Celexa 10 mg daily for depressive disorder Resident #17's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors not specific to resident #17. Review of the behavior monitoring forms lacked evidence that staff identified the target behaviors they hoped to control/improve with the sue of Seroquel and Celexa, and then monitor resident #17 for the presence/absence of those specific behaviors. Resident # 17's monthly medication reviews	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 55	F 428		

completed on 2/22/12, 3/18/12, 4/24/12, 5/12/12, 6/26/12, 7/31/12, 8/28/12, 9/25/12, 10/31/12, 11/28/12, 12/26/12, 1/13/13, and 2/9/13 lacked concerns for target behaviors for the use of Seroquel and Celexa.

During an observation on 5/8/13 at 8:25 a.m., resident #17 sat in his/her room sipping on a Pepsi. The resident did not exhibit any behavioral symptoms.

During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with the administrative staff R and administrative staff A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #17, while the resident received medications such as Seroquel and Celexa , but could not recall the date. Consultant D verified he/she failed to document the discussion he/she had with administrative nurses A and R.

The facility failed to ensure that resident #17 did not receive unnecessary medications related to the lack of monitoring target behaviors while the resident received Seroquel and Celexa.

- Resident #16's 3/14/13 Annual MDS (minimum data set) reported intact cognition with no mood or behavioral symptoms. The resident received anti-depressant and hypnotic therapy during the assessment period.

Resident #16's 3/19/13 Psychotropic CAA (care area assessment) summary revealed the resident was at risk for developing adverse drug reactions due to daily use of Remeron, Celexa and Rozerem. The summary further revealed that resident #16 shows minimal signs of adverse reactions such as mild shaking in the upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 56	F 428		

extremities. The facility will continue to monitor routinely.

Resident #16's 3/12/12 nursing care plan instructed staff to assess for mood and behavioral changes and document on mood and behavioral flow sheet.

Resident #16's 5/1/13 physician ' s orders revealed a renewed order for:

* Remeron (an anti-depressant) 7.5 mg (milligram) at bedtime
* Celexa (an anti-depressant) 20mg daily

Resident #16's montly medication reviews completed on 2/22/12, 3/18/12, 4/24/12, 5/12/12, 6/26/12, 7/31/12, 8/28/12, 9/25/12, 10/31/12, 11/28/12, 12/26/12, 1/13/13, and 2/9/13 lacked concerns for target behaviors for the use of Remeron and Celexa.

During an observation on 5/8/13 at 12:15 p.m., Resident #16 sat at the dining room table, consumed lunch and conversed with his/her tablemates.

During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with the administrative staff R and administrative staff A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #16, while the resident received medications such as Seroquel and Celexa , but could not recall the date. Consultant D verified he/she failed to document the discussion he/she had with administrative nurses A and R.

The facility failed to ensure that resident #16 did not receive unnecessary medications related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 57	F 428		

the lack of evidence of monitoring target behaviors while resident received Remeron, Celexa, and Rozerem.

- Resident #6's Quarterly MDS (minimum data set) assessment dated 3/18/13 identified the resident with moderately impaired cognition, minimal depression, and no behaviors.

Resident #6's 10/2/12 CAA (care area assessment) summary noted the resident ' s use of psychotropic medications.

Resident #6's nursing care plan dated 8/18/12 directed staff to monitor for significant physical and psychological changes, to review and assess the effectiveness of the drugs Trazadone and Lexapro.

Resident #6's 5/1/13 physician ' s orders revealed a renewed order for:

*Trazadone (an anti-depressant) 150 mg (milligrams) every night at bedtime
* Lexapro (an anti-depressant) 20 mg daily

Resident #6's monthly medication reviews completed on 2/22/12, 3/18/12, 4/24/12, 5/12/12, 6/26/12, 7/31/12, 8/28/12, 9/25/12, 10/31/12, 11/28/12, 12/26/12, 1/13/13, and 2/9/13 lacked concerns for target behaviors for the use of Trazadone and Lexapro.

During an observation on 5/8/13 at 8:20 a.m., resident #6 sat in a wheelchair in the dining room and consumed morning meal and did not exhibit any behavioral symptoms.

During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 58 with the administrative staff R and administrative staff A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #6, while the resident received medications such as Seroquel and Celexa , but could not recall the date. Consultant D verified he/she failed to document the discussion he/she had with administrative nurses A and R. The facility failed to ensure that resident #6 did not receive unnecessary medications related to the lack of evidence of monitoring target behaviors while resident received Trazadone and Lexapro. - Resident #2's 5/7/13 signed physician's orders included diagnoses of delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue) with anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). Resident #2's 4/13/13 Quarterly MDS (Minimum Data Set) Assessment reported moderately impaired cognition, mild depression, and delusions. The MDS reported the resident received antipsychotic and antidepressant medications 7 of the 7 observation days. Resident #2's 1/16/13 Behavior CAA (Care Area Assessment) summary reported the resident experienced delusions related to stating his/her deceased spouse and parents being unable to find him/her.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 59 Resident #2's 1/16/13 Mood and Psychotropic Drug Use CAA summaries reported the resident received an antidepressant for depression related to little energy and poor appetite and an antipsychotic medication for delusions. Resident #2's care plan, last reviewed on 4/25/13, instructed staff to monitor for potential side effects and/or adverse consequences for Risperdal (an antipsychotic medication) and Remeron (an antidepressant). Resident #2's 5/7/13 signed physician's orders included renewed orders for Risperdal 0.25 mg (milligrams) orally daily for delusional disorder with anxiety with a start date of 4/4/12 and Remeron 15 mg orally every evening for depression with a start date of 2/8/13. Resident #2's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #2. Review of resident #2's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Risperdal or Remeron, and then lacked monitoring of the presence/absence of those specific behaviors. Review of resident #'2's pharmacy consultant monthly medication reviews between 4/24/12 and 4/23/13 lacked documentation that Consultant D reported irregularities related to the facility's failure to monitor target behaviors/symptoms related to use of Risperdal, nor between 2/19/13 and 4/23/13 for Remeron. During an observation on 5/9/13 at 7:58 a.m., resident #2 ate all of his/her meal independently,	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 60	F 428		

conversed pleasantly with staff, and made no mention of worries related to his/her family being unable to find him/her.

During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with Administrative Nursing Staff R and A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #2, while the residents received medications such as Risperdal and Remeron, but could not recall the date the discussions occurred. Consultant D verified he/she failed to document the discussion with either the previous director of nursing or current interm director of nursing.

The facility failed to ensure the pharmacist consultant reported irregularities to the attending physician and the director of nursing related to the facility's failure to adequately monitor for target behaviors/symptoms while resident #2 received Risperdal and Remeron.

- Resident #26's 5/7/13 signed physician's orders included a diagnosis of fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), panic disorder (a sudden overpowering fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

Resident #26's 4/15/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported no cognition impairment, mild depression, and the resident received antipsychotic and antidepressant medication 7 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 61	F 428		

the 7 observation days. The MDS reported the resident received no antianxiety medication during the observation period.

Resident #26's 4/25/13 Psychosocial Well-being CAA (Care Area Assessment) summary reported the resident received Abilify (an antipsychotic medication) for panic attacks, Cymbalta(an antidepressant medication) for depression and fibromyalgia pain, and Clonazepam (an antianxiety medication) for anxiety.

Resident #26's care plan, last reviewed on 4/25/13, instructed staff to monitor for possible side effects and/or adverse consequences while the resident received Abilify, Cymbalta, Clonazepam, and Remeron. The care plan included interventions to allow the resident time and emotional support during times of distress and monitor the effectiveness of pain medications.

Resident #26's 5/7/13 signed physician's orders included renewed orders with start dates of 2/15/13 for Abilify 2 mg (milligrams) orally daily to treat panic disorder and fibromyalgia, Cymbalta 60 mg orally twice a day to treat depression and fibromyalgia, and Clonazepam 0.5 mg orally three times a day to treat anxiety. The 5/8/13 physician's orders included orders for Remeron (an antidepressant medication) 7.5 mg orally at bedtime and to change Clonazepam to 0.5 mg orally in the morning and at noon and 1 mg in the evening.

Resident #'26's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #26. Review of resident #26's behavior monitoring forms lacked evidence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 62 that staff identified target behaviors they hoped to improve/control with the use of Abilify, Cymbalta, Clonazepam, or Remeron, and then lacked monitoring of the presence/absence of those specific behaviors. Review of resident #26's pharmacist consultant's monthly medication reviews between 2/19/13 and 4/23/13 revealed Consultant D failed to report irregularities to the director of nursing and/or the attending physician related to lack of monitoring target behaviors/symptoms while the resident received Abilify, Cymbalta, Clonazepam, or Remeron. During an observation on 5/9/13 at 8:13 a.m., resident #26 ate all of his/her meal independently and showed no outward signs of distress. During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with Administrative Nursing Staff R and A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #26, while the residents received medications such as Abilify, Cymbalta, Clonazepam, or Remeron, but could not recall the date the discussions occurred. Consultant D verified he/she failed to document the discussion with either the previous director of nursing or current interm director of nursing. The facility failed to ensure the pharmacist consultant reported irregularities to the attending physician and the director of nursing related to the facility's failure to adequately monitor for target behaviors/symptoms while resident #26 received Abilify, Cymbalta, Clonazepam, or Remeron.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 63 - Resident #22's 5/7/13 signed physician's orders included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). Resident #22's 4/19/13 Quarterly MDS (Minimum Data Set) Assessment reported no cognition impairment, no signs of depression, no psychosis, and no behaviors. The MDS reported the resident received antipsychotic and antidepressant medications 7 of the 7 observation days. Resident #22's 10/17/12 Delirium CAA (Care Area Assessment) summary reported the resident became angry with staff, resisted cares, and refused medications prior to admission to an acute psychiatric hospital on 9/26/12. The Delirium CAA reported the resident returned on 10/9/12 to the long term care facility with a diagnosis of delirium secondary to a urinary tract infection. Resident #22's 10/17/12 ADL (Activities of Daily Living) CAA summary reported the resident experienced delusions, screamed out without the ability to articulate why, and accused staff of attempting to hurt him/her. The ADL CAA reported the resident refused to eat or drink at times. Resident #22's 10/17/12 Behavioral CAA summary reported that staff identified no pattern of what caused the resident to display behaviors and the resident received Zyprexa (an antipsychotic medication), Trazadone (an antidepressant medication), and Lexapro (an	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 64 antidepressant medication). Resident #22's care plan, last reviewed on 4/21/13, instructed staff to monitor potential side effects and/or adverse consequences while the resident received Lexapro, Trazadone, and Zyprexa. The care plan instructed staff to monitor for alterations in his/her mood and to document incidents on the "mood and behaviors" form. The care plan instructed staff to monitor for cognitive decline related to dementia. The 5/7/13 physician's orders included renewed orders for Lexapro 20 mg (milligrams) orally daily with a start date of 12/28/11, Trazadone 25 mg orally at bedtime with an as needed order for an additional 25 mg 1 hour after the scheduled dose with a start date of 12/4/12, and Zyprexa 5 mg orally at bedtime with a start date of 2/8/13. Resident #'22's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #22. Review of resident #22's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Lexapro, Trazadone, and Zyprexa, and then lacked monitoring of the presence/absence of those specific behaviors. Review of resident #22's pharmacist consultant's monthly medication reviews between 2/22/12 and 4/23/13 lacked evidence that Consultant D reported irregularities to the director of nursing and/or the attending physician related to lack of monitoring of target behaviors while the resident received Lexapro, Trazadone, and Zyprexa. During an observation on 5/8/13 at 8:18 a.m.,	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 428	Continued From page 65	F 428		

resident #22 received assistance to eat his/her meal and ate the majority of his/her meal without difficulty or episodes of crying or screaming out.

During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with Administrative Nursing Staff R and A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #22, while the residents received medications such as Lexapro, Trazadone, and Zyprexa, but could not recall the date the discussions occurred. Consultant D verified he/she failed to document the discussion with either the previous director of nursing or current interm director of nursing.

The facility failed to ensure the pharmacist consultant reported irregularities to the attending physician and the director of nursing related to the facility's failure to adequately monitor for target behaviors/symptoms while resident #22 received Lexapro, Trazadone, and Zyprexa.

- Resident #7's 5/7/13 signed physician's orders included a diagnosis of depression (progressive mental disorder characterized by failing memory, confusion).

Resident #7's 4/10/13 Quarterly MDS (Minimum Data Set) Assessment reported severely impaired cognition, minimal depression, and experienced delusions. The MDS reported the resident displayed physical behaviors toward others and rejected cares 1 to 3 days during the observation period. The MDS reported the resident received antipsychotic and antidepressant medication 7 of the 7 observation days.

Resident #7's 8/7/12 Psychotropic Drug Use CAA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 428	Continued From page 66 (Care Area Assessment) summary reported the resident received antidepressant medications and staff monitored for potential side effects and adverse reactions. Resident #7's care plan, last reviewed on 3/18/13, instructed staff to assess for mood changes and provide quality listening time if the resident experienced crying episodes. The care plan instructed staff to monitor for potential side effects and adverse consequences while the resident received antidepressant medications. Resident #7's signed physician's ordered included renewed orders for three antidepressant medications: * Celexa 20 mg (milligrams) orally daily with a start date of 3/4/10 * Wellbutrin XL 75 mg orally daily with a start date of 2/8/13 * Remeron 7.5 mg orally at bedtime with a start date of 5/8/13 Resident #7's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #7. Review of resident #7's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Celexa, Wellbutrin, and Remeron, and then lacked monitoring of the presence/absence of those specific behaviors. Review of resident #7's pharmacy consultant's monthly medication review between 2/22/12 and 4/23/13 revealed Consultant D failed to report irregularities to the director of nursing and/or the attending physician related to lack of monitoring target behaviors/symptoms while the resident	F 428		

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F 428	Continued From page 67 received Celexa, Wellbutrin, and Remeron. During an observation on 5/8/13 at 12:01 p.m., resident #7 received assistance to eat his/her meal and ate the majority of his/her meal without difficulty or episodes of depression. During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with Administrative Nursing Staff R and A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #7, while the residents received medications such as Celexa, Wellbutrin, and Remeron, but could not recall the date the discussions occurred. Consultant D verified he/she failed to document the discussion with either the previous director of nursing or current interm director of nursing. The facility failed to ensure the pharmacist consultant reported irregularities to the attending physician and the director of nursing related to the facility's failure to adequately monitor for target behaviors/symptoms while resident #7 received Celexa, Wellbutrin, and Remeron.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 68 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility reported a census of 21 residents. Based on observation, interview, and the record review, the facility failed to maintain a sanitary environment and prevent the development and transmission of disease and infection for residents residing in the long term care unit when staff failed to effectively sanitize toilets. Findings included: - During an observation on 5/8/13 at 8:47 a.m. housekeeping staff H poured Dispatch toilet	F 441		

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F 441	Continued From page 69 cleaner into resident # 2's toilet. He/she cleaned the bathroom and flushed the toilet. The cleaner remained in the toilet a total of 3 minutes. The label on the container of "Dispatch" cleaner directed the user to leave the solution in the toilet for a minimum of 10 minutes in order to ensure effective sanitization. Although requested, the facility failed to provide the policy for sanitizing the resident rooms, including sanitization of bathrooms/toilets. During an interview on 5/18/13 at 8:55 a.m. housekeeping staff H reported he/she flushed the toilet approximately 3 minutes after adding Dispatch to the toilet. Housekeeping Staff H lacked awareness of the requirement to leave the Dispatch cleaner in the toilet a minimum of 10 minutes in order to ensure effective sanitization. On 5/14/13 at 10:00 a.m. infection control staff G reported he/she expected the housekeeping department to follow the instructions listed on the bottle The facility failed to maintain a sanitary environment in order to prevent the development and transmission of disease and infection when staff failed to follow the manufacturer's recommendations to ensure effective sanitization of the toilet in resident #2's room.	F 441		